MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

16970

CERTIFICATE OF DEATH

★ Reg. Dist. No. 90

1. PLACE OF DEATH:
County: Cecil
City or town: Fredericktown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Fredericktown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary E. Bigge

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 10 1872

8. AGE: Years: 73 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Frank Bigge
13. Birthplace: Md.

MOTHER — 14. Maiden name: Susie Hessie
15. Birthplace: Md.

16. Informant
Address: Georgetown, Md.

17. Buried (Burial, cremation, or removal — which?) Date thereof: Nov. 8 1945 (month) (day) (year)
Cemetery or crematory: Cecilton
Location: Cecilton, Md.

18. Funeral director: Edward Pellow
Address: Millington, Md.

19. Nov 8th 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6 1945, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1940 to Nov. 6 1945 and that I last saw h... alive on Nov. 3, 1945

Immediate cause of death	DURATION
Paralysis right side	1940
Due to: Apoplexy	1940
Due to:	
Other conditions: Prostate — Stomach — Bowels (Include pregnancy within 3 months of death)	1 week

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: H. W. Crouse M.D.
M. D. or other
Address: Chesapeake City, Md. Date signed: 11/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

10971

CERTIFICATE OF DEATH

★ Reg. Diat. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perryville Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Perryville, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Frenchtown Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Mabel Burns Bines

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Married

6.(b) Name of husband or wife: Roland Bines

6.(c) If alive, give age: Years

7. Birth date of deceased (mo., day, yr.): Nov. 17, 1924

8. AGE: Years	Months	Days	If less than one day
20	11	22	hrs. min.

9. Birthplace: West Chester, Chester Co. Pa
(Town, county, and state)

10. Usual occupation: Home Wife.

11. Industry or business

FATHER
12. Name: Benjamin Burns.
13. Birthplace: Chester Co. Pa

MOTHER
14. Maiden name: Matilda Burke
15. Birthplace: Chester Co. Pa.

16. Informant: Benjamin Burns
Address: Havre de Grace, Md. Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 12, 1945 (month) (day) (year)

Cemetery or crematory: West Nottingham

Location: Colora, Md.

18. Funeral director: Lewis Patterson & Son

Address: Perryville, Md.

19. Nov 10 1945 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 8 1945, at 8.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Internal hemorrhage	
Due to: Perforation of	
Due to: Bullet wound	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Internal Hemorrhage

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of: 11-8-45

Where did injury occur? Perryville Cecil Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: 22. Rifle. Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County, M. D. or other

Address: Rising Sun Md. Date signed: 11-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

10972

Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Union Hospital

How long in hospital or institution? no time

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Del. County: Newcastle

City or town: Summit Bridge Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Barbara Lynn Brady

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Single

6.(b) Name of husband or wife

6.(c) If olive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 25 1944

8. AGE: Years: 1 | Months: 7 5 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Westville N. J.

(Town, county, and state)

10. Usual occupation: Child

11. Industry or business

FATHER — 12. Name: William H. Brady 2nd

FATHER — 13. Birthplace: Mt Pleasant, Del.

MOTHER — 14. Maiden name: Catherine Daugherty

MOTHER — 15. Birthplace: Townsend, Del.

16. Informant: Mrs. H. Brady 2nd

Address: Elkton Rural Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 4 1945 (month) (day) (year)

Cemetery or crematory: Forest Cemetery

Location: Middletown Delaware

18. Funeral director: H. W. Pippin

Address: Elkton Md

19. Nov 3 1945 (Date rec'd by registrar) F. R. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Drowned.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 11-1-43

Where did injury occur? Summit Bridge (City or town) Newcastle (County) Del. (State)

Injured at home, farm, industry, public place (where?): Home.

Means of injury: Fell in Creek injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner Cecil County

M. D. or other

Address: Rising Sun Md. Date signed 11-1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

10973

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil

City or town Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hrs

Hospital, Institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? 6 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil

City or town Charlestown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Helen E Brumit

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 3 - 1945

8. AGE: Years — | Months 1 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace Charlestown, Cecil Co Md

(Town, county, and state)

10. Usual occupation none

11. Industry or business —

FATHER 12. Name Charles W Brumit

13. Birthplace West Virginia

MOTHER 14. Maiden name Mildred Meadows

15. Birthplace West Virginia

16. Informant Charles W Brumit

Address Charlestown Md

17. Removed (Burial, cremation, or removal. Which?) Date thereof Nov 26-45 (month) (day) (year)

Cemetery or crematory B. Land Family Cemetery

Location Hicks, West Virginia

18. Funeral director Jesse R. Lewis

Address North East, Md

19. Nov 25 1945 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1945 at 1:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov - 24 1945 to Nov 25 1945 and that I last saw h.r.s. alive on Nov. 24 1945

Immediate cause of death	DURATION
Bronchio-Pneumonia	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C S Collins M. D. or other

Address North East, Md Date signed 11-25-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22d)

CERTIFICATE OF DEATH

16974

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 5 mos. 24 days

Hospital, institution, or street address where death occurred:
Veterans Administration

How long in hospital or institution? 3 yrs. 5 mos. 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Florida County: Palm Beach

City or town: West Palm Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No.: None
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I V

3.(a) FULL NAME: CARROLL, Timothy J.

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Edith Browning - divorced

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 26, 1886

8. AGE: Years	Months	Days	If less than one day
59	10	1	..... hrs. ..... min.

9. Birthplace: Beaverton, Mass.
(Town, county, and state)

10. Usual occupation: Professional Golfer

11. Industry or business: Professional Golfing- teaching

FATHER
12. Name: Jeremiah Carroll
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Colonna
15. Birthplace: England

16. Informant: Records - Veterans Administration
Address: Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov. 29, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery,
Location: Baltimore, Md.

18. Funeral director: Pennington & Son
Address: Havre De Grace, Md.

19. Nov. 29 1945 Irma E. Daniels Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27 1945, at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 1942, to November 27 1945 and that I last saw him alive on November 27 1945

Immediate cause of death	DURATION
Disease of the Coronary Arteries	over 1 yr
Due to: Chronic Endocarditis, valvular disease	over 1 yr
Due to:	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ——

Date of op. ——

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: —— Date of ——

Where did injury occur? —— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ——

Means of injury —— Injured at work? ——

23. SIGNATURE: A. E. Trollinger

A. E. TROLLINGER, LT. COL., M.C., Actg. DIR.

Address: Vets. Adm., Perry Point, Md. Date signed: 11-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1975

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: BAINBRIDGE, MARYLAND.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 119 days.

Hospital, institution, or street address where death occurred:
USNH, NTC, BAINBRIDGE, MARYLAND.

How long in hospital or institution? 108 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: North Carolina County: UNKNOWN

City or town: Halifax
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route #1, Box 173
(If rural, give LOCATION)

2.(a) If veteran, name war: WORLD WAR II

3.(a) FULL NAME

John Henry COBB

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	NEGRO	MARRIED

6.(b) Name of husband or wife: MRS. LILLIAN COBB

6.(c) If alive, give age: UNKNOWN years

7. Birth date of deceased (mo., day, yr.): 4 July 1914

8. AGE: Years	Months	Days	If less than one day
31	4	11	..... hrs. ..... min.

9. Birthplace: KINSTON, N.C.
(Town, county, and state)

10. Usual occupation: U.S. NAVY

11. Industry or business: U.S. NAVY

FATHER
12. Name: UNKNOWN
13. Birthplace: UNKNOWN

MOTHER
14. Maiden name: UNKNOWN
15. Birthplace: UNKNOWN

16. Informant: U.S. NAVAL HOSPITAL, NAV TRA CEN

Address: BAINBRIDGE, MARYLAND.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 11-28-45 (month) (day) (year)

Cemetery or crematory: Branch Funeral Home

Location: Enfield, North Carolina

18. Funeral director: Lucas Patterson & Son

Address: Garysville, Md.

19. Nov 28 19 45 Irma E. Daughtry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 November 19 45 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 July 19 45 to 24 November 19 45 and that I last saw h... im alive on 24 November 19 45

Immediate cause of death	DURATION
EDEMA, GLOTTIS	1 day
Due to	
Due to	
Other conditions: Tonsillitis, Acute	5 days

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: Confirmed diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: D. D. NORTHROP
M. D. or other

Address: USNH, NTC, BAINBRIDGE, MD. Date signed: 11-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

1976

★ Reg. Diat. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 81 years
Hospital, institution, or street address where death occurred: Cecil ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perryville (If outside city or town limits, write RURAL and give nearest town)
Street No.: Cecil ave. (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Jennie W. Craig

3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Alexander Craig
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Nov. 2 1864.
8. AGE: Years: 81 Months: Days: If less than one day: hrs. min.
9. Birthplace: Perryville, Cecil Co. Md. (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business:
FATHER 12. Name: James L. Ward
FATHER 13. Birthplace: Elkton, Md
MOTHER 14. Maiden name: Mary E. Boyd.
MOTHER 15. Birthplace: Principio Furnace, Md.
16. Informant: Frances Keesey
Address: Perryville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 28, 1945 (month) (day) (year)
Cemetery or crematory: Principio
Location: Principio Furnace, Md
16. Funeral director: Lewis Patterson & Son
Address: Perryville, Md.
19. Nov. 28 1945 Irma E. Dougherty (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 1945, at 7 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 1945 to November 25 1945 and that I last saw h. alive on November 25 1945
Immediate cause of death: Cerebral Hemorrhage — DURATION: 6 hr.
Due to:
Due to:
Other conditions: Generalized Arteriosclerosis — 10 yr.
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other
Address: Perryville, Md. Date signed 11/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

CERTIFICATE OF DEATH

10977

Reg. Diat. No. 95

1. PLACE OF DEATH:
County: Cecil
City or town: Rising Sun
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 76 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Rising Sun
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William Wilson Creswell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Annie Creswell
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Feb 20 1869

8. AGE: Years	Months	Days	If less than one day
76	6	7	hrs. min.

9. Birthplace: Lewisburg Ind.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Jacob Creswell
13. Birthplace

MOTHER
14. Maiden name: Julia Ann Deth
15. Birthplace

16. Informant: Mrs. Annie Creswell
Address: Rising Sun Md.

17. (Burial, cremation, or removal. Which?) Date thereof: Nov 30, 1945 (month) (day) (year)
Cemetery or crematory: Brookings
Location: Rising Sun, Md.
18. Funeral director: Ralph M Reed
Address: Rising Sun, Md.
19. 11/29 19 45 - Emmett Mottington Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 27 1945 at 10.30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R L Dodson MD
M. D. or other
Address: Rising Sun Md. Date signed 11-27-45

Medical Examiner
Cecil County

Permit issued 11-29-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10978

CERTIFICATE OF DEATH

★ Reg. Dist. No. 97

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Union Hosp
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: (Infant) Dean

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 4 - 1945

8. AGE: Years — Months — Days — If less than one day: ____ hrs. 50 min.

9. Birthplace: Elkton Cecil Co. Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Cecil Dean
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Pauline Boruggs
15. Birthplace: West Virginia

16. Informant: Cecil Dean
Address: North East Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 5-1945 (month) (day) (year)
Cemetery or crematory: Methodist
Location: North East Md

18. Funeral director: Joseph R. Frank
Address: North East Md

19. Nov 5 1945 (Date rec'd by registrar) F H Freas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4 1945, at 5 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____
and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Neonatal	
Due to: Asphyxia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: R. L. Dodson M.D. M. D. or other
Address: Rising Sun Md Date signed 11-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

10979

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton and R.F.D. 3

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 66 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton and R.F.D. 3

(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Parkedale Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Georgeanna DeVinney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widow

6.(b) Name of husband or wife: George DeVinney

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 12 - 1855

8. AGE:

Years	Months	Days	If less than one day
90	1	23	hrs. min.

9. Birthplace: Kent Co Del

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: Benjamin Knotts

13. Birthplace: Kent Co Md

MOTHER

14. Maiden name: Elizabeth Harrow

15. Birthplace: Kent Co Md

16. Informant: Miss Elizabeth DeVinney

Address: Elkton Md R.D. 3

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 6 1945 (month) (day) (year)

Cemetery or crematory: Head of Christiana

Location: Near Bryans Del

18. Funeral director: R. J. Jones

Address: Marydel

19. Nov 7 1945 (Date rec'd by registrar) F K Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 5 1945, at 7.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1. 1945, to Nov 5 1945 and that I last saw h.. alive on Nov 5 1945

Immediate cause of death	DURATION
Bronchopneumonia	2 dys
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Lester C Meade M.D. M. D. or other

Address: 126 W. Main Newark Del Date signed 11/5/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33)

CERTIFICATE OF DEATH

10980

Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton - Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton -

(If outside city or town limits, write RURAL and give nearest town)

Street No.: N. High Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: William Charles Feehley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Ada Feehley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 18 - 1871

8. AGE: Years	Months	Days	If less than one day
74	7	14	..... hrs. ..... min.

9. Birthplace: Elkton - Md. (Town, county, and state)

10. Usual occupation: Freight & Station agent (Retired)

11. Industry or business: Penn. R.R.

FATHER — 12. Name: Roger Feehley

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Mary Murphy

MOTHER — 15. Birthplace: Ireland

16. Informant: Mrs. Ada Feehley

Address: N. High St. Elkton - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 5 1945 (month) (day) (year)

Cemetery or crematory: Elkton Cemetery

Location: Elkton, Md.

18. Funeral director: H. W. Pippin & Son per W.L.P.

Address: Elkton Md.

19. Nov 5 1945 (Date rec'd by registrar) H R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 2d 1945, at 5.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb-15- 1945, to Nov-3- 1945 and that I last saw h.im alive on Nov-3-1945 19.....

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Senile since Feb	
Due to: General arteriosclerosis	unknown
with hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. H. McKnight M.D. M. D. or other

Address: Elkton - Md. Date signed 11/4/45

M

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

10981

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred: Union Hosp
How long in hospital or institution? 13 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Samuel Ferree

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov 16 1945

8. AGE: Years - | Months | Days | If less than one day: 15 hrs. ____ min.

9. Birthplace: Elkton Cecil Md
(Town, county, and state)

10. Usual occupation: -

11. Industry or business: -

FATHER
12. Name: John J. Ferree
13. Birthplace: Scranton Pa

MOTHER
14. Maiden name: Helen Rowland
15. Birthplace: Elkton Md

18. Informant: Helen Rowland Ferree
Address: Elkton Md

17. Elkton burial — Date thereof: Nov 19 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Elkton cemetery
Location: Elkton Md

18. Funeral director: H. W. Pippin
Address: Elkton Md

19. Nov 19 1945 — F. R. Frazer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16 1945 at 5-17 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16 1945 to Nov. 16 1945 and that I last saw him alive on Nov. 16 1945

Immediate cause of death	DURATION
Pneumonia	3 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: [illegible] Date signed: Nov. 16 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

16982

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs. 7 mos. 20 days

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? 8 yrs. 7 mos. 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ____ County: ____

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 676 - 4th St., N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: FOWLER, Michael N.

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 20, 1893

8. AGE:

Years	Months	Days	If less than one day
52	5	9	____ hrs. ____ min.

9. Birthplace: Prince George Co., Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: --

FATHER
12. Name: Charles E. Fowler
13. Birthplace: District of Columbia

MOTHER
14. Maiden name: Mary Harmon
15. Birthplace: Prince George Co., Md.

18. Informant: Records - Veterans Administration,
Address: Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: December 3, 1945 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Fort Myer, Va.

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. Dec. 1 19 45 (Date rec'd by registrar) Irene E. Dwight Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29 19 45 at 10:10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 19 37 to November 29 19 45 and that I last saw h... im ...alive on November 29 19 45

Immediate cause of death	DURATION
Disease of Coronary Arteries with Myocardial Infarction	6 mos.
Due to: Arteriosclerosis, general	Undet.
Pleurisy, with effusion	Undet.
Due to:	
Other conditions: Dementia Praecox, Catatonic	8 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: As above listed.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: A. E. TROLLINGER, LT. COL., MC, USA (or other) R.

Address: Vets. Adm., Perry Point, Md. Date signed: 11-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

10983

★ Reg. Dist. No. 92

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Eckton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Union Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
Street No. RD 1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Baby Gibbs

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 29, 1945

8. AGE: Years | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Eckton (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Curtis Winfield Hayden
13. Birthplace: Chesapeake City Md.

MOTHER
14. Maiden name: Mary A. Gibbs
15. Birthplace: Chesapeake City Md

16. Informant: father
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 29 '45 (month) (day) (year)
Cemetery or crematory: Manor Cemetary
Location: near Chesapeake City Md.

18. Funeral director: father
Address

19. Nov 29 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29 19 45 at 1 20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Prematur	
Due to 7 mo. Gestation	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R L Dodson M.D. M. D. or other
Address: Rising Sun, Md. Date signed: 11-24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11984

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days.

Hospital, Institution, or street address where death occurred: Cecil Gen. Hosp. Elkton Md.

How long in hospital or institution? 12 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Charlestown.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William C Henry.

3.(b) Social Security Number –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	married

6.(b) Name of husband or wife: Emma Henry

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Mch 24 1880

8. AGE: Years: 65 | Months: 7 | Days: 8 | If less than one day: ... hrs. ... min.

9. Birthplace: Batesville Ala

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: Jacob Henry

13. Birthplace: Vanneville Ohio

MOTHER 14. Maiden name: Charlotte Crawford

15. Birthplace: No information

16. Informant: Emma Henry

Address: Charlestown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 4 1945 (month) (day) (year)

Cemetery or crematory: Charlestown

Location: Charlestown. Md

18. Funeral director: H. W. Pippin

Address: Elkton Md

18. Nov 3 1945 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1 1945 at 5:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
(a) Bronchial Pneumia	
Fracture of Skull	
Due to: Fracture Left arm	
Fracture of pelvis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 10-19-45

Where did injury occur: Charlestown Cecil Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home.

Means of injury: Fell from ladder Injured at work? yes.

23. SIGNATURE: R. E. Dodson M.D. Medical Examiner Cecil County

M. D. or other

Address: Rising Sun Md Date signed: 11-1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Diat. No. 109896

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point Veterans. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Mr Youngthere

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: North East. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George B Jackson.

3.(b) Social Security Number 218-01-7390

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 25 1904

8. AGE:

Years	Months	Days	If less than one day
40	10	28	..... hrs. ..... min.

9. Birthplace: North East Md. (Town, county, and state)

10. Usual occupation: Mason. Helper.

11. Industry or business

FATHER — 12. Name: Frank E Jackson

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Lucile Culley.

MOTHER — 15. Birthplace: Maryland.

16. Informant: Lucile Jackson

Address: North East Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-26-45 (month) (day) (year)

Cemetery or crematory: Methodist

Location: North East Md

18. Funeral director: Joseph R Freeman

Address: North East Md

19. Nov 26 1945 (Date rec'd by registrar) Irene E Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 23 1945, at 7.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Cardiac Dilatation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R E Dodson MD Medical Examiner Cecil County

Address Perry Point Md M. D. or other Date signed 11-24-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

16986

CERTIFICATE OF DEATH

Reg. Diat. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md. (Veterans Administration)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mo. 21 days

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ~~Pennsylvania~~ County: Fayette

City or town: Dunbar
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box 44
(If rural, give LOCATION)

2.(a) If veteran, name war: WW Service None - Peacetime

3.(a) FULL NAME: JORDAN, Isaac F.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: (single)

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): August 10, 1912

8. AGE:	Years	Months	Days	If less than one day
	33	3	14	- hrs. - min.

9. Birthplace: Percy, Pa.
(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: -

FATHER
12. Name: Fuller Hogsett Jordan
13. Birthplace: Percy, Pa.

MOTHER
14. Maiden name: Mary B. Hardy
15. Birthplace: Dunbar, Pa.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 11-26-45 (month) (day) (year)

Cemetery or crematory: Sylvian Heights Cemetery

Location: Uniontown, Pa.

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. Nov. 26 (Date rec'd by registrar) 19 45 Irma E. Dayhoff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24 19 45 at 3:05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 3 19 45, to Nov. 24 1945 and that I last saw him alive on November 24 1945

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	1 yr.
Due to:	
Due to:	
Other conditions: Dementia Precox, Paranoid	5½ yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.: -

Autopsy results: Not performed Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: A. E. Rollinger, Lt. Col., M.C. M. D. of other

Clinical Director

Address: Veterans Administration, Perry Point, Md. Date signed: 11-25-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10,987

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: VETERANS ADMINISTRATION, PERRY POINT, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs. 11 mo. 1 Da.
Hospital, institution, or street address where death occurred:
VETERANS ADMINISTRATION, PERRY POINT, MD.
How long in hospital or institution? SAME AS ABOVE

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County: —
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 216 New York Avenue, Washington, D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: LEE, EVANDER

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: MAMIE GARRIS LEE
6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): April, day unknown, 1899

8. AGE: Years	Months	Days	If less than one day
46	7	unknown	— hrs. — min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: —

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) ✓ Date thereof 11- 5-1945 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
✓ Location: Arlington, Va.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Nov 3, 19 45 — Irma E. Langford, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 2, 19 45, at 5:25A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1, 19 37, to November 2, 19 45, and that I last saw him alive on November 2, 19 45

Immediate cause of death	DURATION
Syphilis of the Central Nervous System, Meningo-encephalitic type	Over 7 yrs.
Due to	
Due to	
Other conditions: Psychosis with Syphilis of the Central Nervous System, Meningo-encephalitic type (Include pregnancy within 3 months of death)	Over 7 yrs

Major findings of operations: —
Date of op.: —
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: A. E. Troellinger
A.E. TROELLINGER, LT.COL., M.C. CLINICAL DIRECTOR
Address: VETERANS ADMINISTRATION, PERRY POINT, Md. Date signed: 11-3-45

17988

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, Institution, or street address where death occurred: 256 E Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 256 E. Main St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: W. Liam H. Maguire

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Married

6.(b) Name of husband or wife: Marion Woolfred Maguire

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Oct 10, 1854

8. AGE: Years	Months	Days	If less than one day
91	1	15	...hrs. ...min.

9. Birthplace: Madison, Md (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER — 12. Name: Hugh McGuire

FATHER — 13. Birthplace: Madison, Md

MOTHER — 14. Maiden name: Louisa Banks

MOTHER — 15. Birthplace: Baltimore, Md

16. Informant: Mrs Henry Lowndes Address: Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 29/45 (month) (day) (year)

Cemetery or crematory: Cambridge

Location: Cambridge, Md

18. Funeral director: H. W. Pippin

Address: Elkton, Md

19. Nov 27 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 1945 at 4 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 6 1945 to Nov. 25 1945 and that I last saw him alive on Nov. 25 1945

	DURATION
Immediate cause of death: Broncho-pneumonia	Nov. 16
Due to: Cardio-vascular-renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Orford H. Spreaker, M.D. M. D. or other

Address: Elkton, Md Date signed Nov. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

16989

Reg. Dist. No. 95

1. PLACE OF DEATH:
County: Cecil outside Rising Sun
City or town: (If outside city or town limits, write RURAL and give nearest town) Md.
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Lou Emma Mendenhall

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	Married

6.(b) Name of husband or wife: William Howard Mendenhall
Sept 30th 1866 6.(c) If alive, give age 83 years
7. Birth date of deceased (mo., day, yr.) Sept 30 1866

8. AGE: Years	Months	Days	If less than one day
79			hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Thomas Wright
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Moriah Whitcraft
15. Birthplace: Pennsylvania

16. Informant: James Mendenhall
Address: Nottingham R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 29-45 (month) (day) (year)
Cemetery or crematory: Rosebank Calvert Md.
Location: Calvert Md.

18. Funeral director: J. E. Ingram
Address: Rising Sun Md.

19. Nov 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 1945, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945, to November 25 1945
and that I last saw her alive on Nov 25 1945

Immediate cause of death	DURATION
Congestive Heart Failure	11 months
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: F. S. Robinson M.D. (M. D. or other)
Address: Oxford, Pa. Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

16990

Reg. Diat. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Principio
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: N. J. County: Hudson
City or town: Jersey City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 279 Baldwin Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: II 32333897

3. (a) FULL NAME: Maurice Olsen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1911

8. AGE: Years	Months	Days	If less than one day
34			hrs. min.

9. Birthplace: (Town, county, and state)
10. Usual occupation:
11. Industry or business
FATHER 12. Name:
13. Birthplace
MOTHER 14. Maiden name:
15. Birthplace
16. Informant:
Address
17. Transportation (Burial, cremation, or removal. Which?) Date thereof Nov. 21, 1945 (month) (day) (year)
Cemetery or crematory: Edgar E. Lent, Funeral Director
Location: 55 Bentley Ave., Jersey City, N. J.
18. Funeral director: Howard K. McComas & Son
Address: Abingdon Md.
19. Nov. 21 1945 (Date rec'd by registrar) Marie M. Rockdale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18 1945, at 19 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Compound fracture of Skull	
Due to Comp. Fracture of Rt leg.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.
Autopsy results: multiple fractures of Skull, Compound fracture of leg, Contusion of brain
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 11-18-45
Where did injury occur? Principio (City or town) Cecil (County) Md (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Fell off barn Injured at work?

23. SIGNATURE: R. C. Dodson M.D. Medical Examiner Cecil County
M. D. or other
Address: Rising Sun Md. Date signed 11-18-45

I have received the remains of the above-named deceased for burial. Howard K. McComas & Son

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10991

★ Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, Institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Florence Potts

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John C Potts

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 21 1895

8. AGE:

Years	Months	Days	If less than one day
50	10	12	..... hrs. ..... min.

9. Birthplace: North East, Cecil Co Md

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Hiram W Shallcross

13. Birthplace: Md

MOTHER

14. Maiden name: Anna A Talbot

15. Birthplace: Penna

18. Informant: Elizabeth E Goodnow

Address: North East Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 12 1945 (month) (day) (year)

Cemetery or crematory: St Marys Episcopal

Location: North East Md

18. Funeral director: Joseph R Evans

Address: North East Md

19. Nov 10 1945 (Date rec'd by registrar) H P Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 9 1945 at 1 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 18 1945 to Nov. 9 1945 and that I last saw her alive on Nov. 9, 1945

Immediate cause of death	DURATION
Recto-sigmoid carcinoma —	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Mass at recto-sigmoid —

Date of op.

Autopsy results: Nons —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Dr. Lloyd N. Spreeder, M.D.

M. D. or other

Address: Elkton, Md. Date signed: 11/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

16992 P

Reg. Dist. No. 9V

1. PLACE OF DEATH:
County: Cecil
City or town: Principio, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 hours
Hospital, institution, or street address where death occurred:
Principio, Md.
How long in hospital or institution? 1 month 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 300 E. 32nd St.
(If rural, give LOCATION)
2.(a) If veteran, name war: W.W.2

3.(a) FULL NAME: SHOEMAKER, Leonard W.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ——
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 3.1923

8. AGE: Years: 22 | Months: - | Days: 22 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cleveland, Ohio (Town, county, and state)
10. Usual occupation: None
11. Industry or business: -

FATHER
12. Name: Dudley M.Shoemaker
13. Birthplace: Richmond, Va.

MOTHER
14. Maiden name: Anna V.Flannerty
15. Birthplace: Baltimore, Md.

18. Informant: Hospital record
Address: V.A.Perry Point, Md.

17. Removal Burial Date thereof 11-28-45 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Nun. Cath.
Location: Old Frederick Rd Baltimore, Md.

18. Funeral director: John A. Moran
Address: 3000 E. Baltimore, St. Balto., Md.

19. 11-27 1945 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25, 1945, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21, 1945 to Nov. 24, 1945 and that I last saw him alive on Nov 24 1945

Immediate cause of death	DURATION
Lacerations of the right lung.	
liver, pericardium and vessels	
Due to xxx multiple internal hemorrhage	
Due to	
Due to	
Other conditions: Dementia precox, paranoid type	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: homicide Date of: Nov 25,45
Where did injury occur? Principio (City or town) Cecil (County) Maryland (State)
Injured at home, farm, industry, public place (where?): public
Means of injury: Gunshot wounds Injured at work?

23. SIGNATURE: P.L.Dodson MD Medical Examiner for Cecil County
M. D. or other
Address: Elkton md Date signed: 11/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

10993

Reg. Diat. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 14 days

Hospital, institution, or street address where death occurred:
Veterans Administration

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County: Allegheny

City or town: Turtle Creek, Pa.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 311 Clugston Street
(If rural, give LOCATION)

2.(a) If veteran, name war: S.A.W.

3.(a) FULL NAME: Anson V. Todd

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: //// Mrs. Jessie T. Todd

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 13, 1862

8. AGE: Years	Months	Days	If less than one day
82	5	27	..... hrs. ..... min.

9. Birthplace: Belmont, Ohio
(Town, county, and state)

10. Usual occupation: Maintenance

11. Industry or business

FATHER — 12. Name: Archibald Todd
13. Birthplace: Ohio

MOTHER — 14. Maiden name: Margaret Griffin
15. Birthplace: Ohio

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 11-11-45 (month) (day) (year)

Cemetery or crematory: Oakgrove Cemetery, Piedmont, O.

Location: .....

18. Funeral director: Pennington & Son

Address: Havre de Grace, Maryland

19. Nov. 11 19 45 Dane E. Mangold Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10 19 45, at 2:20PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 27, 19 45, to Nov. 10, 19 45 and that I last saw him alive on November 10, 19 45

Immediate cause of death	DURATION
Arteriosclerosis, General & Cerebral	10 yrs.
Due to:	.....
Due to:	.....
Other conditions: Thrombosis, Cerebral	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: - - - Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - - - Date of - - -

Where did injury occur? - - - (City or town) - - - (County) - - - (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury - - - Injured at work? - -

23. SIGNATURE: A. E. Trollinger

A. E. TROLLINGER, Lt. Col., M.C. Clinical Dir.

Address: Perry Point, Md.

Date signed: 11/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

10994

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton - Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton - RD 5
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Charles Toog

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Dec 25 - 1851

8. AGE: Years	Months	Days	If less than one day
63 ~~75~~	10	21	... hrs. ... min.

8. Birthplace: Cecil County Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: John Toog
13. Birthplace: Cecil County - Md
MOTHER 14. Maiden name: Mary A Carder
15. Birthplace: Cecil County - Md
16. Informant: Turner Toog - brother
Address: Elkton - Md RD
17. burial (Burial, cremation, or removal. Which?) Date thereof Nov 19 '45 (month) (day) (year)
Cemetery or crematory: Cherry Hill Cemetery
Location: Cherry Hill md.
18. Funeral director: Florence E. Abernathy
Address: Elkton RD 5 md
19. Nov 18 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 16 1945, at 8.45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 1945, to Nov 16 1945, and that I last saw him alive on Nov 16 1945

	DURATION
Immediate cause of death: Cancer of Liver	unknown
Due to:	
Due to:	
Other conditions: Nephritis, acute	unknown

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: T. H. Knight M.D.
M. D. or other
Address: Elkton - Md Date signed Nov 17-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1642

CERTIFICATE OF DEATH

10995

Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Cecilton Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Cecilton Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Robert Long.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 15 1867.

8. AGE: Years	Months	Days	If less than one day
78.	4	22	..... hrs. ..... min.

9. Birthplace: Andora. Cecil Co Md.

(Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business

FATHER

12. Name: John Long.

13. Birthplace: Cecil Co. Md.

MOTHER

14. Maiden name: Mary Jane MacCauley

15. Birthplace: Cecil Co Md.

16. Informant: Farmer. Long.

Address: Elkton Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Nov 9 '45 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Church Hill

18. Funeral director: Talbert & Abernathy

Address: Elkton R.D. 3 Md

19. Nov 8 1945 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6 1945 at 2.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Gun shot wound of head.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 11-6-45

Where did injury occur? Elkton Rural Cecil Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Shot gun. Injured at work?

23. SIGNATURE: R. le Dodson MD

M. D. or other

Address: Rising Sun Md Date signed 11-6-45

Medical Exam... for Cecil Coun...

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

1098

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo

Hospital, institution, or street address where death occurred: 169 Hollingsworth Manor

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 169 Hollingsworth Manor

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Susan E. Treadway

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh	Married

6.(b) Name of husband or wife: Charles Treadway

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 25 1880

8. AGE: Years 65 | Months 9 | Days 23 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Circleville W Va (Pughly Co)

(Town, county, and state)

10. Usual occupation: at Home

11. Industry or business:

FATHER — 12. Name: Edward Biggs

13. Birthplace: W. Va

MOTHER — 14. Maiden name: Mary Lincus

15. Birthplace: Va

16. Informant: Millie Lively

Address: 169 Hollingsworth Manor

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 26, 1945 (month) (day) (year)

Cemetery or crematory: Biggs Cem't

Location: Oak Hill Circleville W Va

18. Funeral director: H. W. Lipkins

Address: Elkton, Md.

19. Nov 24 19 45 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23 19 45 at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 45, to Nov. 23 19 45

and that I last saw h[illegible] alive on Nov. 23 19 45

Immediate cause of death: Chronic Interstitial Nephritis

Due to:

Due to:

Other conditions: Diabetis Mellitus

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Herbert Robins, M.D.

M. D. or other

Address: Elkton Md. Date signed 11/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

★ 10997

Reg. Diat. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
union Hospital 3 day
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 124 Bridge St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Eliza Trimble

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Wm F Trimble
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 27 1853

8. AGE: Years	Months	Days	If less than one day
92	1	21	hrs. min.

9. Birthplace: Andora Cecil md
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business:

FATHER
12. Name: Wm H Spatt
13. Birthplace: Andora Cecil Md

MOTHER
14. Maiden name: Martha Jamison
15. Birthplace: Andora Cecil Md

16. Informant: Wm F. Trimble Jr
Address: Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 20 1945 (month) (day) (year)
Cemetery or crematory: Elkton Presbyterian
Location: Elkton Md
18. Funeral director: H. W. Pippin
Address: Elkton Md

19. Nov 19 1945 (Date rec'd by registrar) F H Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 17 1945 at 11 50 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 2 1945 to Nov. 17 1945 and that I last saw h... alive on Nov. 16 1945

Immediate cause of death	DURATION
Bronchio-pneumonia	Oct 29 - 45
Cardio-vascular renal disease	
Due to	
Due to	
Other conditions: Hrs —	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Orland W. Spreeler, MD
M. D. or other
Address: Elkton, Md. Date signed: Nov. 17

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37)

CERTIFICATE OF DEATH

10398

Reg. Dist. No. 94

1. PLACE OF DEATH:
County: Cecil
City or town: N E Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: North East, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rose Ann Wood

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Hiram Joseph Tuttle
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 26 1860

8. AGE: Years: 84 | Months: 11 | Days: 28 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Chappaque Westchester Co. N. Y.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Cornelius Donohue
13. Birthplace: Cork Ireland

MOTHER
14. Maiden name: Anne Hart
15. Birthplace: Cork Ireland

16. Informant: Mrs John Bosterick
Address: N. E. Md

17. (Burial, cremation, or removal. Which?) Burial — Date thereof: (month) Nov (day) 27 (year) 45

Cemetery or crematory: Methodist
Location: N. E. Md

18. Funeral director: Joseph R. Grant
Address: North East Md

19. (Date rec'd by registrar) 11/27 19 45 — Registrar: Lucia L. Owens

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26 1945 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1944 to Nov 26 1945 and that I last saw her alive on Nov. 26 1945

Immediate cause of death	DURATION
Myocarditis	1 Years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C. B. Collins M. D. or other
Address: North East, Md Date signed 11-25-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15